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### A SELECTIVE REVIEW OF THE LITERATURE ON ETHNOCULTURAL ASPECTS OF PTSD

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E. Huland Spain, PhD<sup>3</sup>

During the past twenty years, the growth of interest in ethnocultural aspects of reactions to traumatic events has been indicated by publication of numerous books, technical reports, and journal articles on a broad spectrum of ethnic populations and ethnic aspects of PTSD. As noted by the present authors in a recent article (Marsella, Friedman & Spain, in press), information on ethnocultural aspects of PTSD is widely distributed across publications that focus on different: 1) ethnocultural groups (e.g., Afro-Americans, American Indians, Asian-Americans, Cambodians, Hispanics); 2) traumatized populations (e.g., war veterans, refugees, torture victims, prisoner-of-war survivors, rape and crime victims, survivors of natural and human-made disasters); 3) traumatic events (e.g., Vietnam War, Afghanistan War, Northern Ireland Conflict, Buffalo Creek Disasters, Chernobyl, Hiroshima, Three Mile Island, San Ysidro Massacre, Khmer Rouge genocide, Nazi Holocaust, refugee camp internment, rape, criminal assault); and 4) clinical topics (e.g., epidemiology, measurement of PTSD, clinical diagnosis, alternative therapies).

In the article by Marsella, Friedman and Spain (in press), we presented the first comprehensive summary of this ethnocultural literature by reviewing over 150 publications on conceptual and methodological issues and research findings on traumatized populations consisting mostly of refugees, veterans, and survivors of natural disasters. Other reviews have focused on specific cross-cultural aspects of PTSD. Penk and Allen (1991) summarized the research literature on clinical assessment among ethnic minority Vietnam War veterans. De Girolamo (in press) summarized the literature on treatment and prevention of PTSD among victims of natural disasters in different countries. Also, Friedman and Jaranson (in press) summarized the literature on PTSD among refugees.

It can be difficult to interpret much of the emerging literature on ethnocultural aspects of PTSD. Besides the enormous size and diversity of this literature, there are considerable variations in the quality of the published reports. Quite simply, many publications are not based on scientifically acceptable methodologies for conducting cross-cultural research. Therefore, serious questions can be raised

with respect to the validity of some reported findings because of insensitivities to ethnocultural aspects of psychopathology, assessment, and treatment. For example, many existing studies and clinical reports have used Western criteria and assessment instruments to diagnose the presence of PTSD. These criteria are often ethnocentric and biased. Cross-cultural research must consider indigenous expressions of disorder, idioms of distress, and ethnocultural sensitivities in assessment including instrument norms, formats, language, and concepts. Failure to do so can result in false positives and false negatives, as well as misunderstandings regarding the PTSD experience.

*International Epidemiological and Clinical Literature.* Although there are no published literature reviews concerning ethnocultural variations in the epidemiology of PTSD, several publications have summarized the literature on populations that are considered to be at high risk for PTSD, such as refugees, immigrants, and concentration camp survivors. Weisæth and Eitinger (1991a, 1991b) compiled a bibliography of traumatic reactions among European refugee, concentration camp, and veteran populations. Friedman and Jaranson (in press) summarized the refugee experience with regard to risk for traumatic exposure and applicability of the PTSD conceptual model. Garcia-Peltoniemi's (1991) recent review of the historical literature is especially noteworthy. Her comprehensive summary of psychopathology among refugees is "must reading" for anyone interested in the epidemiology and clinical expressions of PTSD and related disorders across cultures. Her report supports a direct relationship between traumatic experiences and a spectrum of neurotic and psychotic disorders, including PTSD. An example of an increasing number of studies by American investigators on the prevalence of PTSD among Indochinese refugees is provided by Kinzie et al. (1986, 1990). In a related article, Kinzie (1989) discusses problems of assessment and treatment of PTSD among Cambodian, Laotian, and Vietnamese refugees from a cross-cultural perspective.

There are a number of clinical and epidemiological studies of political and family traumas and natural disasters in various countries. De la Fuente's (1990) article on the psychological impact of the 1985 Mexican earthquakes reported that 32% of the victims displayed PTSD while 19% had generalized

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anxiety and 13% had depression. Weisæth (1989) found a direct relationship between the severity of trauma exposure and PTSD symptoms among survivors of a paint factory explosion in Norway. In de Girolamo's (in press) literature review, he concluded that natural disasters are an important source of psychiatric adjustment difficulties among survivors regardless of the country in which the disaster occurred. Such data suggest that PTSD can occur in any ethnocultural group following exposure to trauma and argues against the position that PTSD is a culture-bound syndrome that is only expressed among traumatized individuals from Western/industrialized cultures.

However, there is controversy in some circles regarding the applicability of the PTSD diagnosis to traumatized individuals from non-Western backgrounds, especially with respect to refugees. Punamäki (1989) asserts that stress models are inappropriate for conceptualizing politically induced violence and repression, and Eisenbruch (1991) argues that the refugee experience is much better understood in a cultural bereavement than in a PTSD context. These issues are addressed by Friedman and Jaranson (in press).

*Ethnocultural Differences Among War Veterans.* Among the many publications on PTSD in American military veterans, some have focused on ethnocultural variations in the prevalence and clinical phenomenology of PTSD among black (Laufer et al., 1984; Penk et al., 1989) and Hispanic (Piña, 1985) Vietnam veterans. Data seem to show that these groups are more likely than white veterans to develop PTSD. Green et al. (1990) reported a higher prevalence of PTSD among black than among white Vietnam veterans. The National Vietnam Veterans Readjustment Study, a comprehensive national epidemiological survey of current and lifetime prevalence rates of PTSD among black, Hispanic, female, and white Vietnam war-zone veterans, found that current and lifetime prevalence estimates were higher among blacks and Hispanics than among whites (Kulka et al., 1990). Another report suggesting that Hispanic Vietnam War-zone veterans were at greater risk for PTSD than whites is provided by Escobar et al. (1983), who also found that most Hispanic veterans with PTSD were comorbid for at least one other DSM-III diagnosis. To date, there have been no investigations of PTSD among American Indian or Asian-American Vietnam War veterans, although the National Center for PTSD is currently undertaking such a study.

Several authors have discussed factors that might have placed blacks at higher risk for PTSD, such as: racism in the military and at home as well as limited economic opportunities (Allen, 1986); a "tripartite adaptational dilemma" consisting of bicultural identity, institutional racism, and residual stress from trauma (Parson, 1985); and the exacerbation of traumatic stress by racism and non-membership in the majority culture (Penk & Allen, 1991). However, Green et al. (1990) point out that data suggesting higher

PTSD prevalence rates among blacks compared to whites are confounded by the effects of substance abuse, early life stressors, and differential severity of war-zone exposure. This cautionary advice is largely borne out by Kulka et al. (1990), who found that when data were controlled for amount of war-zone trauma exposure, prevalence differences between blacks and whites disappeared and Hispanic versus white prevalence differences were greatly reduced.

The most extensive research on war-zone-related PTSD from another country has been provided by Solomon and associates, who have published a score of studies on PTSD among Israeli soldiers and veterans. A representative example is Solomon et al. (1987), which reported that 59% of Israeli soldiers who fought in the 1982 war in Lebanon had PTSD one year after the end of the war. Literature on war-zone trauma from European nations is reviewed by Weisæth and Eitinger (1991a, 1991b).

*Assessment Issues.* Although there are important methodological concerns regarding the assessment of PTSD in different ethnocultural cohorts, few publications have addressed this matter. In fact, most studies of non-white, non-Western PTSD populations have tended to use standard (Western/DSM-III) clinical methods. Questions have been raised about the validity of existing studies because of problems in linguistic, conceptual, normative, and scalar equivalency. Despite this, it is noteworthy that PTSD symptomatology has been detected consistently across a variety of non-Western cohorts assessed by the use of Western diagnostic instruments.

Penk and Allen (1991) discuss the need for a specialized approach to the diagnosis and treatment of black Vietnam veterans. Some investigators even have developed culturally sensitive assessment techniques in studies on different ethnocultural groups, such as Cambodian refugees (Mollica et al., 1992). For the most part, however, there has been little effort to develop culturally specific instruments for diagnosing and studying PTSD among non-white populations. Marsella et al. (in press) underscore the importance of this failure, and suggest that ethnocultural variations in PTSD would be observed more clearly and consistently if cross-culturally sensitive research and clinical methods were used in the study of PTSD.

*Conclusions.* Ethnocultural studies of PTSD offer an opportunity to identify the universal and the culture-specific aspects of the PTSD experience by comparing ethnocultural group differences in the distribution, expression, and treatment of PTSD. Identifying these differences can help clinicians adjust their practices and procedures to accommodate the shared and the unique aspects of the PTSD experience. While responses to a traumatic event may share some universal features, especially as the trauma becomes more severe, ethnocultural factors may play an important role in the individual's vulnerability to PTSD, the expression of PTSD, and the treatment responsiveness of PTSD.

## SELECTED ABSTRACTS

ALLEN, I.M. (1986). **Posttraumatic stress disorder among black Vietnam veterans.** *Hospital and Community Psychiatry*, 37, 55-61. Because of racism in the military and racial and social upheaval in the United States during the Vietnam War years, as well as limited opportunities for blacks in the postwar period, black veterans of the Vietnam War often harbor conflicting feelings about their wartime experiences and have difficulty rationalizing brutality against the Vietnamese. As a result, black veterans suffer from PTSD at a higher rate than white veterans. Diagnosis and treatment of PTSD in black veterans is complicated by the tendency to misdiagnose black patients, by the varied manifestations of PTSD, and by patients' frequent alcohol and drug abuse and medical, legal, personality, and vocational problems. The author presents his and others' recommendations about ways to treat black veterans with PTSD.

DE GIROLAMO, G. (in press). **International perspectives on the treatment of and prevention of post-traumatic stress disorders.** In J.P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes*. New York: Plenum Publishing Company. The present chapter reviews some of the international literature on natural disasters and violence as two major sources of PTSD, with special emphasis upon developing countries. The chapter summarizes some of the conceptual issues associated with disasters, including the complexities involved in definition and measurement. The epidemiology of disorders associated with disasters is reviewed, with special attention to the epidemiology of PTSD and related mental and behavioral disorders. Following this review, attention is given to the prevention and treatment of PTSD following natural disasters. The author then reviews the literature on man-made violence (i.e., war and political violence) and PTSD, and offers a discussion of the prevention and treatment of PTSD associated with violence. This chapter closes with a detailed discussion of topics needing additional research. [AJM]

DE LA FUENTE, R. (1990). **The mental health consequences of the 1985 earthquakes in Mexico.** *International Journal of Mental Health*, 19, 21-29. Several thousand persons lost their lives, and many more suffered the deaths of family members and friends or were left homeless, when earthquakes struck Mexico City on 19 September 1985. Everything happened so quickly that many surely died without being clearly aware of what was happening. The collective drama is undoubtedly one of the most painful experiences in the history of our country. One aspect of this disaster was its effects on the mental health of the victims and the rest of the population.

ESCOBAR, J.I., RANDOLPH, E.T., PUENTE, G., SPIWAK, F., ASAMEN, J.K., HILL, M. & HOUGH, R.L. (1983). **Post-traumatic stress disorder in Hispanic Vietnam veterans: Clinical phenomenology and sociocultural characteristics.** *Journal of Nervous and Mental Disease*, 171, 585-596. The complex symptomatology of Hispanic Vietnam veterans receiving treatment for PTSD was explored with the National Institute of Mental Health Diagnostic Interview Schedule, a structured diagnostic interview that yields current and lifetime operational diagnoses (e.g., DSM-III). Social networks and level of acculturation of these veterans were also examined and compared to those of a "control" group and a sample of veterans with DSM-III schizophrenic disorder (both samples included only Hispanic veterans from the Vietnam and

post-Vietnam eras). All subjects reported heavy combat stress and met DSM-III criteria for PTSD. Most were very symptomatic and had significant social impairment. PTSD was rarely seen as a discrete entity but appeared instead mixed with symptom clusters cutting across various DSM-III diagnoses. Social networks of PTSD veterans were intermediate in size, frequency of contact with network members, and network density to those of the comparison groups. A distinctive feature of the PTSD group was the high proportion of negative relationships with close family members, especially spouses. "Highly" symptomatic PTSD veterans reported significantly smaller networks, fewer contacts outside the close family circle, and more negative emotionality directed toward family members than "minimally" symptomatic veterans. While all Hispanic groups studied were not significantly different in level of acculturation, PTSD veterans appeared more alienated from their cultural heritage than the other groups. The severe and polymorphous psychopathology found among these veterans suggests that "rap" groups alone may not constitute an adequate therapeutic approach and that more formal psychiatric therapies should be additionally considered in the management of Vietnam-linked PTSD.

FRIEDMAN, M.J. & JARANSON, J.M. (in press). **The applicability of the PTSD concept to refugees.** In A.J. Marsella, T.H. Borneman, S. Ekblad & J. Orley (Eds.), *Amidst peril and pain: The mental health and well-being of the world's refugees*. Washington, DC: American Psychological Association. The authors present the PTSD model and argue that it appears to offer a useful approach for conceptualizing the psychological impact of traumatic exposure on refugees despite objections from some quarters that PTSD is not an appropriate model either for the refugee experience per se or for individuals from non-Western societies. The authors maintain, however, that a sensitive cross-cultural approach is essential because ethnocultural and religious factors may have a particularly powerful and differential influence on the expression of PTSD in non-Western refugee populations, especially with respect to avoidant numbing symptoms. Arguing from a neurobiological perspective, they also hypothesize that a universal response to traumatic stress may often be obscured by ethnocultural differences in the phenomenological expression of post-traumatic symptomatology. In this context, they present a comprehensive review of literature on the psychological impact of trauma on refugees. Finally, they describe the clinical implications of such a model and show that trauma-focused assessment and treatment must always be offered within a broader context that integrates ethnocultural factors, problems of language, metaphors and symbolism and awareness of adaptational/acculturation pressures. [MJF]

GARCIA-PELTONIEMI, R.E. (1991). **Epidemiological perspectives.** In J. Westermeyer, C.L. Williams & A.N. Nguyen (Eds.), *Mental health services for refugees* (pp. 24-41). Washington, DC: U.S. Government Printing Office. The chapter provides a detailed review and discussion of the research and clinical literature on the epidemiology of mental disorders among refugees and immigrant populations. A summary of the demographic and chronological factors affecting the development of psychopathology in these populations, with special attention given to risk factors that have been identified through various international publications, is also offered. The chapter is divided into sections which examine the epidemiology of mental disorders in refugee and host



populations and general population surveys, since these represent two critical strategies for determining the impact of refugee status on mental disorders. Among the risk factors in mental disorders among refugees that are reviewed are acculturation/social distance, language, conditions of migration, conditions of resettlement, sponsorship, ethnicity, and previous history of psychiatric disorder. [AJM]

GARCIA-PELTONIEMI, R.E. (1991). **Clinical manifestations of psychopathology.** In J. Westermeyer, C.L. Williams & A.N. Nguyen (Eds.), *Mental health services for refugees* (pp. 42-55). Washington, DC: U.S. Government Printing Office. The present chapter reviews the research and clinical literature associated with different patterns of clinical disorders among refugees. The chapter includes a detailed summary of different patterns of psychopathology among World War II displaced persons, Hungarian Revolution refugees, Cuban refugees, and Southeast Asian refugees. Following this section, the author summarizes findings regarding affective disorders, psychoses, somatization, anxiety disorders, and PTSD, paranoid disorders, organic brain syndromes, substance abuse, antisocial disorders, and "culture-bound disorders." The author concludes that the refugee experience may outweigh ethnic and cultural differences in psychopathology, although the importance of culturally sensitive treatment and assessment is continually emphasized. [AJM]

GREEN, B.L., GRACE, M.C., LINDY, J.D. & LEONARD, A.C. (1990). **Race differences in response to combat stress.** *Journal of Traumatic Stress*, 3, 379-393. A number of authors have written poignantly about the black experience in the Vietnam war; however, very little research has addressed this topic. The present report studied race differences in preservice, stressor, and outcome variables in a community sample of 181 war veterans. Blacks reported higher levels of stressors and outcome, particularly for PTSD-related symptoms. The results suggested that the relationship between stressors and outcome can be defined by a common regression line for blacks and whites, and that the high symptom levels observed for blacks in the sample were accounted for by higher levels of stressors during their war experience. The cognitive coping mode of avoidance did not conform to this pattern and showed higher levels for blacks even controlling for other factors. Potential cultural origins of this difference were noted.

KINZIE, J.D., SACK, W., ANGELL, R., MANSON, S. & BEN, R. (1986). **The psychiatric effects of massive trauma on Cambodian children: I. The children.** *Journal of the American Academy of Child and Adolescent Psychiatry*, 25, 370-376. This report, using standardized interviews by psychiatrists, describes the psychiatric effects on 40 Cambodian high school students in the United States who suffered massive trauma from 1975 to 1979. They endured separation from family, forced labor and starvation, and witnessed many deaths because of the Pol Pot regime. After 2 years of living in refugee camps, they emigrated to the United States at about age 14. Four years after leaving Cambodia, 20 (50%) developed PTSD; mild, but prolonged, depressive symptoms were also common. Psychiatric effects were more common and more severe when the students did not reside with a family member.

LAUFER, R.S., GALLOPS, M.S. & FREY-WOUTERS, E. (1984). **War stress and trauma: The Vietnam veteran experience.** *Journal of Health and Social Behavior*, 25, 65-85. Previous studies of the effect of war on men's life have focused primarily on the effects

of combat exposure. However, reliance on combat exposure, defined in the traditional sense, as the sole indicator of war trauma ignores aspects of the phenomenon present in the Vietnam conflict. In this paper, we develop and test a model of war trauma that contains three elements: (1) combat experience, (2) witnessing abusive violence, and (3) participation in abusive violence. Using a sample of 350 Vietnam veterans, we apply a hierarchical regression analysis to scales of psychiatric symptomatology to test this model. The findings confirm that each of the three elements of war trauma affects postservice psychological states of veterans in significant and different ways. Furthermore, exposure to abusive violence is found to have significantly different effects for black and white veterans. Qualitative material from transcripts is used to explore the meaning of the different pattern of findings for these groups. The findings emphasize the importance of specifying what constitutes "the experience" when attempting to link traumatic experiences to subsequent psychological patterns.

MARSELLA, A.J., FRIEDMAN, M.J. & SPAIN, E.H. (in press). **Ethnocultural aspects of PTSD: An overview of issues, research, and directions.** In J.M. Oldham, A. Tasman & M. Riba (Eds.), *American Psychiatric Press Review of Psychiatry*, 12. Washington, DC: American Psychiatric Press. This chapter offers a comprehensive overview of the research and clinical literature associated with issues, research findings, and directions regarding ethnocultural aspects of PTSD. The chapter reviews findings on PTSD among different ethnocultural groups, PTSD victim populations, traumatic events, and clinical topics (e.g., epidemiology, measurement, treatment), among refugee and military veteran populations. The chapter discusses the conceptual and methodological requirements necessary for valid cross-cultural research of PTSD, especially as these pertain to valid clinical diagnosis, case determination in epidemiology studies, measurement equivalence, and therapeutic efficacy. The chapter concludes that although there have been many studies on ethnocultural aspects of PTSD, limitations in meeting cross-cultural research requirements leave many questions about racial, ethnic, and cultural variations in the etiology, expression, and treatment of PTSD unanswered. [AJM]

MOLLIKA, R.F., CASPI-YAVIN, Y., BOLLINI, P., TRUONG, T., TOR, S. & LAVELLE, J. (1992). **The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees.** *Journal of Nervous and Mental Disease*, 180, 111-116. There are no valid and reliable cross-cultural instruments capable of measuring torture, trauma, and trauma-related symptoms associated with the DSM-III-R diagnosis of PTSD. Generating such standardized instruments for patients from non-Western cultures involves particular methodological challenges. This study describes the development and validation of three Indochinese versions of the Harvard Trauma Questionnaire (HTQ), a simple and reliable screening instrument that is well received by refugee patients and bicultural staff. It identifies for the first time trauma symptoms related to the Indochinese refugee experience that are associated with PTSD criteria. The HTQ's cultural sensitivity may make it useful for assessing other highly traumatized non-Western populations.

PARSON, E.R. (1985). **The intercultural setting: Encountering black Viet Nam veterans.** In S.M. Sonnenberg, A.S. Blank & J.A. Talbott (Eds.), *The trauma of war: Stress and recovery in Viet Nam veterans* (pp. 359-387). Washington, DC: American Psychiatric

Press. The focus of this chapter is on treating black Vietnam veterans in cross-cultural psychotherapy and counseling. Topics treated: black Vietnam veterans in contemporary society; acquiring transracial competency with African-Americans; developing transexperiential competency with Vietnam veterans; clinical assessment of black veterans; implications of cross-cultural psychotherapy research for black Vietnam veterans; the intercultural treatment setting: critical ingredients of a useful psychotherapy.

PENK, W.E. & ALLEN, I.M. (1991). **Clinical assessment of post-traumatic stress disorder (PTSD) among American minorities who served in Vietnam.** *Journal of Traumatic Stress*, 4, 41-66. This paper will review issues in clinical assessment of minority combat veterans who served in Vietnam. We will specify differences and similarities for assessing minorities within the context of evaluating the larger combat veteran population. As a way of introducing a need for specialized diagnosis and treatment, we will present data demonstrating that minorities may be characterized as a distinct group among Vietnam combat veterans; data demonstrating differential rates of PTSD and other psychological disorders; as well as differences in vocational, social, educational, physical and health adjustment along with differential rates of health services utilization. Throughout this paper, we will attempt to give a historical perspective to the role of the minority soldier before, during, and after military service in Vietnam, as well as inter-related civilian events that impacted minority veterans. We will review pertinent theories that explain the higher PTSD rates among minority veterans — considering the special nature of the Vietnam War and its impact on young minority soldiers. We will frankly discuss problems we have observed about clinician prejudice that adversely affect clinical assessment and treatment. We emphasize that every combat veteran, regardless of racial background, is a unique individual with his or her own unique story to tell. We are aware, though, that cross-cultural interactions, because of factors internal to both client and clinician, can impede, if not preclude, effective therapeutic encounter. We recognize that providing information about minorities may do relatively little to alter deeply rooted prejudice of an unconscious nature. We hope to address the issues of ethnicity in ways that do not stir clinical resistance but rather that enhance clinician sensitivity, curiosity, and confidence.

PENK, W.E., ROBINOWITZ, R., DORSETT, D., BELL, W. & BLACK, J. (1989). **Posttraumatic stress disorder: Psychometric assessment and race.** In T.W. Miller (Ed.), *Stressful life events* (pp. 525-552). Madison, Connecticut: International Universities Press. Do ethnic groups differ in adjustment following their exposure to, and participation in, life-threatening experiences? Aspects of this question bearing on cultural differences in coping with stress were investigated by comparing measures of current adjustment of 618 Vietnam era and theater veterans seeking treatment for substance abuse. Black noncombat veterans reported appreciably less disturbance on the MMPI than did white noncombat veterans. Among veterans with light combat exposure, blacks scored lower than whites on scales 2, 3, 4, and 0; only on scale 9 did blacks score higher. Black heavy combat veterans scored higher than white heavy combat veterans on scales F, 1, 6, and 8. The pattern for heavy combat veterans is in the opposite direction of

all black-white substance abuser comparison studies published to date. The findings underscore the importance of identifying contributions of antecedent conditions (such as trauma) to psychopathology before drawing rigidly fixed conclusions about ethnic comparison studies. [Adapted from Text]

SOLOMON, Z., WEISENBERG, M., SCHWARZWALD, J. & MIKULINCER, M. (1987). **Posttraumatic stress disorder among frontline soldiers with combat stress reaction: The 1982 Israeli experience.** *American Journal of Psychiatry*, 144, 448-454. One year after the 1982 Lebanon War, the authors assessed the prevalence, type, and severity of PTSD in a large representative sample of Israeli soldiers who had been treated for combat stress reactions. Comparisons were made with a group of soldiers who had fought in the same battles but had not been treated for this reaction. A dramatically higher percentage of soldiers with combat stress reaction (59%) than soldiers without combat stress reaction (16%) developed PTSD. Age was significantly associated with PTSD. The authors discuss the differential quality of PTSD among both groups as well as the factors facilitating recovery.

WEISÆTH, L. (1989). **The stressors and the post-traumatic stress syndrome after an industrial disaster.** *Acta Psychiatrica Scandinavica. Supplementum*, 80, 25-37. Acute and subacute post-traumatic stress reactions are reported among 246 employees of an industrial factory which was severely damaged by an explosion and fire. 66 A-subjects had narrow escape experiences (high stress exposure group), while 59 B-subjects were less severely exposed (medium stress exposure group). The 121 C-subjects were not present at work when the explosion occurred (low stress exposure group). A response rate of 97.6 percent was achieved at the primary examination, and a 100 percent response at the 7 months follow-up.

The frequency and intensity of post-traumatic stress reactions were linked to the severity (A, B, C) of the stress exposure; specific post-traumatic anxiety reactions were reported by more than 80 percent of A-subjects. The reactions appeared immediately or within hours, only 5 percent of A had delays of a few weeks. While 24.3 percent of A had State Anxiety Inventory scores 1 week post-disaster higher than 60, 8.5 percent of B and 2.5 percent of C had similar scores. Depressive reactions, social withdrawal, guilt, shame, and irritability were less frequent, and appeared nearly always concomitant with anxiety symptoms. While the anxiety symptoms made up a tight knit syndrome, the less frequent non-anxiety symptoms were linked to the post-traumatic anxiety syndrome. The subjects' fears reflected the trauma, they feared inanimate objects, and there were hardly any paranoid ideations.

The disaster exposure of the A and B but not of the C group members constituted a stressor which fulfilled the PTSD stressor criterion of the DSM-III-R. A minority of the C group developed a post-traumatic stress syndrome. After 7 months, all 30 post-traumatic stress reactions were more frequent and severe in the A than B group which again differed from the C group. Irritability was the only post-traumatic stress reaction that increased in frequency and intensity during the 7 months observation period. The findings represent evidence that supports the face validity, descriptive, and construct validity of the PTSD diagnosis.

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## ADDITIONAL CITATIONS

### Annotated by the Authors

ARROYO, W. & ETH, S. (1985). **Children traumatized by Central American warfare.** In S. Eth & R.S. Pynoos (Eds.), *Post-traumatic stress disorder in children* (pp. 101-120). Washington, DC: American Psychiatric Press.

Presents a very useful review of the effects of war and civil strife on children and adolescents both with respect to their psychological adjustment and to their development. DSM-III diagnostic data are presented on 30 Central American refugees, 17 years old or younger, who had been exposed to warfare before entering the United States. The discussion focuses on the occurrence and expression of PTSD among these youngsters.

BECERRA, R.M. (1982). **The Hispanic Vietnam veteran: Mental health issues and therapeutic approaches.** In R.M. Becerra, M. Karno & J.I. Escobar (Eds.), *Mental health and Hispanic Americans: Clinical perspectives* (pp. 169-180). New York: Grune & Stratton.

Reviews existing literature on the mental health of Hispanic Vietnam veterans and discusses negative influences on postmilitary adjustment, such as racism in the military and low socioeconomic status both before and after the military. The author uses three case studies to illustrate the problems faced by Hispanic veterans and makes recommendations for successfully treating this population.

BOEHNLEIN, J.K. (1987). **Culture and society in post-traumatic stress disorder: Implications for psychotherapy.** *American Journal of Psychotherapy*, 41, 519-530.

Discusses cross-cultural aspects of psychotherapy for PTSD. The author begins by describing universal healing concepts and then focuses on specific cultural belief systems along with traditional family and social role expectations that affect recovery from severe trauma. Case histories on two female Cambodian concentration camp survivors are offered as illustrative examples.

BOEHNLEIN, J.K., KINZIE, J.D., BEN, R. & FLECK, J. (1985). **One-year follow-up study of posttraumatic stress disorder among survivors of Cambodian concentration camps.** *American Journal of Psychiatry*, 142, 956-959.

Reports on a one-year follow-up study of twelve Cambodian concentration camp survivors who initially had PTSD. After 12 months, five patients no longer met diagnostic criteria for PTSD and three others were less symptomatic. Psychotherapy combined with pharmacotherapy was more effective in reducing intrusive and arousal than avoidant/numbing symptoms.

CERVANTES, R.C., SALGADO DE SNYDER, V.N. & PADILLA, A.M. (1989). **Posttraumatic stress in immigrants from Central America and Mexico.** *Hospital and Community Psychiatry*, 40, 615-619. Cited in *PTSD Research Quarterly*, 1(1), 1990.

EISENBRUCH, M. (1991). **From post-traumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees.** *Social Science and Medicine*, 33, 673-680.

Argues that the refugee experience is much better understood in the context of cultural bereavement which results from loss of home, social networks, institutions, routines, and surroundings. It is argued that coping with such losses as well as relocation/

acculturation pressures can sometimes produce a phenomenological picture that meets DSM-III-R criteria for PTSD but is actually a normal and healthy rehabilitative response.

KINZIE, J.D. (1989). **Therapeutic approaches to traumatized Cambodian refugees.** *Journal of Traumatic Stress*, 2, 75-91. Abstracted in *PTSD Research Quarterly*, 1(1), 1990.

KINZIE, J.D., BOEHNLEIN, J.K., LEUNG, P.K., MOORE, L.J., RILEY, C. & SMITH, D. (1990). **The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees.** *American Journal of Psychiatry*, 147, 913-917. Cited in *PTSD Research Quarterly*, 1(3), 1990.

KINZIE, J.D. & FLECK, J. (1987). **Psychotherapy with severely traumatized refugees.** *American Journal of Psychotherapy*, 41, 82-94.

Focuses on cross-cultural factors affecting psychotherapy with patients from traditional societies. The emphasis is clinical rather than conceptual with detailed attention to therapeutic issues and strategies that are likely to arise when Euro-American therapists attempt to treat non-Western refugees with PTSD. Case examples include Cambodian, Ethiopian, Iranian, and Romanian patients.

KROLL, J., HABENICHT, M., MACKENZIE, T., YANG, M., CHAN, S., VANG, T., NGUYEN, T., LY, M., PHOMMASOUVANH, B., NGUYEN, H., VANG, Y., SOUVANNASOTH, L. & CABUGAO, R. (1989). **Depression and posttraumatic stress disorder in Southeast Asian refugees.** *American Journal of Psychiatry*, 146, 1592-1597. Cited in *PTSD Research Quarterly*, 1(1), 1990.

KULKA, R.A., SCHLENGER, W.E., FAIRBANK, J.A., HOUGH, R.L., JORDAN, B.K., MARMAR, C.R. & WEISS, D.S. (1990). **Trauma and the Vietnam War Generation.** New York: Brunner/Mazel. Abstracted in *PTSD Research Quarterly*, 1(3), 1990.

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PARSON, E.R. (1990). **Post-traumatic psychocultural therapy (PTpsyCT): Integration of trauma and shattering social labels of the self.** *Journal of Contemporary Psychotherapy*, 20, 237-258.

Discusses the interaction between psychological traumatization and ethnocultural considerations in psychotherapy. Black veterans are highlighted to demonstrate the complexities of cultural and traumatic factors. The importance of recognizing the powerful and detrimental impact of stigmatizing social labels borne by certain groups of patients is discussed, as well as a specialized treatment model – *post-traumatic psychocultural therapy* – to help minority persons whose presenting complaints include suffering the aftereffects of psychological trauma. As the model integrates trauma and cultural issues, the veteran-therapist dynamics, cultural stigma, and the therapist's achieving of transexperiential and transcultural competencies in therapy are emphasized.



PIÑA, G. (1985). **Diagnosis and treatment of post-traumatic stress disorder in Hispanic Viet Nam veterans.** In S.M. Sonnenberg, A.S. Blank & J.A. Talbott (Eds.), *The trauma of war: Stress and recovery in Viet Nam veterans* (pp. 389-402). Washington, DC: American Psychiatric Press.

Describes key factors that influence Hispanic identity and emphasizes the great ethnocultural diversity that distinguishes different groups of Hispanics. Such a complex array of factors affects the clinical expression of PTSD among Hispanic Vietnam veterans and has important implications for assessment and treatment. Culture-specific interventions are described.

PUNAMÄKI, R. (1989). **Political violence and mental health.** *International Journal of Mental Health*, 17, 3-15.

Argues that stress models are inappropriate for conceptualizing politically induced violence and repression because they reduce social, political, and historical problems to the individual level. The thrust of this argument is that an appropriate psychological coping response under the abnormal conditions of political repression and torture might be labeled pathological by therapists who ignore the socio-political context in which the psychological response takes place.

ROZÉE, P.D. & VAN BOEMEL, G. (1989). **The psychological effects of war trauma and abuse on older Cambodian refugee women.** *Women and Therapy*, 8, 23-50.

Studied 30 female Cambodian refugees who had subjective complaints of blindness that were not explained by physical exams. Degree of subjective blindness was positively related to duration of traumatic exposure and to war-related nightmares. The author argues that the life histories of these women suggest environmental rather than intrapsychic etiology and suggests culturally relevant treatment interventions.

WEISÆTH, L. & EITINGER, L. (1991). **Research on PTSD and other post-traumatic reactions: European literature.** *PTSD Research Quarterly*, 2(2), 1-7.

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WESTERMEYER, J. (1989). **Cross-cultural care for PTSD: Research, training, and service needs for the future.** *Journal of Traumatic Stress*, 2, 515-536.

Comprehensively discusses the many complex issues pertaining to treatment of refugees, immigrants, and other minority groups. Factors addressed include: a) balancing the impact of past violence with current adverse conditions; b) cross-cultural assessment and treatment; and c) exacerbation of post-traumatic symptoms by acculturation pressures. The implications of these factors for research, training, and service needs are reviewed.

## PILOTS UPDATE

We now have more than 3,700 papers indexed in the PILOTS database. We are closing in on our goal of including in PILOTS all English-language literature on PTSD that appears in the leading databases used by medical and social science researchers and clinicians. We thought that readers might be interested in knowing how we produce and distribute the database.

The first step is to identify possibly relevant material. We have identified several journals which publish a considerable number of significant papers on PTSD, and we examine each issue of these journals on a regular basis. We obtain reprints or copies of each relevant article, and place them in the queue for indexing. We also subscribe to three editions of *Current Contents on Diskette* (Clinical Medicine, Life Sciences, and Social and Behavioral Sciences) which we examine weekly, using the Current Contents software to generate reprint request forms whenever we see a potentially interesting paper cited. With each reprint request we send a letter explaining the database project and soliciting any additional papers that the recipient might think relevant to PILOTS.

To ensure that comprehensive coverage of the traumatic stress literature in PILOTS does not depend entirely on the judgement of one bibliographer, we also search a wide range of other databases to locate relevant material. These include the National Library of Medicine's MEDLINE and CATLINE; PsycINFO, the online version of *Psychological Abstracts*; EMBASE, a database produced by the publishers of *Excerpta Medica*; and the online versions of *Social Work Abstracts* and *Sociological Abstracts*. We plan to search many other databases, covering such fields as criminology, law, and religion. We are also beginning a project of identifying and collecting all U.S. government publications on PTSD.

Once we have identified relevant publications, we need to obtain them. We receive many through the courtesy of their authors, and are always happy to receive unsolicited papers. We have at our disposal the library at the VA Medical Center in White River Junction as well as the resources of the Dartmouth College

Libraries. Through commercial document delivery services and through interlibrary loan we obtain needed publications not available locally.

Although we use other databases and bibliographies to locate papers, we do not incorporate their indexing into PILOTS. To avoid infringing the intellectual property rights of their producers and to ensure a uniform method for presenting bibliographical data and subject content, we index each document ourselves. We use authority lists to assure uniform entry of author names, journal titles, and psychological tests; and all papers are assigned subject descriptors from the PILOTS Thesaurus, a continually evolving controlled vocabulary of terms invented specifically for the PILOTS database.

Once descriptors are assigned, the paper is entered into the database, which we produce on Macintosh computers using Pro-Cite software. Every three months the accumulated entries, as well as any modifications of earlier entries, are transferred to tape and sent to the Combined Health Information Database in Maryland; shortly thereafter they are added to the CHID file on the BRS databank, and are then available for searching worldwide. In addition, every quarter the database files (both in Macintosh Pro-Cite format and in an MS-DOS file which can be imported into Pro-Cite's MS-DOS version) are mounted on an Internet host computer at Dartmouth College. These may be retrieved, free of charge, by anyone with access to the Internet through a procedure called "anonymous ftp." For instructions, write to Fred Lerner at the National Center in White River Junction or send an e-mail message to "fred.lerner@dartmouth.edu". Those same files will be available for purchase on diskette from the National Technical Information Service as soon as the technical details can be worked out; for details, enquire of Fred Lerner.

As always, we welcome comments and suggestions from PILOTS users and potential users, and we solicit the cooperation of everyone working in the traumatic stress field in making our bibliographic work known among their colleagues.

## PTSD RESEARCH AT THE NEW ORLEANS VAMC

Patricia B. Sutker, PhD and Madeline Uddo, PhD

Focusing on veterans of four wars and subsets of highly traumatized combatants, the multidisciplinary PTSD research team at the DVA Medical Center in New Orleans is conducting studies of war-related sequelae targeting three primary objectives: 1) documenting early and long-term consequences of war trauma and extraordinary stress on cognitive, emotional, and behavioral functioning; 2) identifying pre- and post-trauma person and environment variables contributing to risk of negative war stress outcomes over time; and 3) describing the unique psychosocial needs of combat veterans of World War II (WWII), the Korean conflict, Vietnam, and Operation Desert Storm (ODS). We believe our work has relevance for understanding the human capacity to survive and manage extreme stress and for developing therapeutic tools to lessen, and even prevent, negative psychological outcomes of combat.

In a project supported by DVA Medical Research, 225 WWII and Korean conflict former prisoners of war (POWs) and 75 combat controls completed an extensive neuropsychological and psychological assessment protocol. Findings suggested marked, long-standing psychiatric residuals of war trauma, including full-blown PTSD, in approximately 75-90% of former POWs; revealed a complex constellation of personality features and psychiatric comorbidities among POW survivors; highlighted the influence of stressor severity and person factors on psychopathology and neuropsychological outcomes; and confirmed relationships between POW complaints of memory, learning, and other problem-solving limitations and cognitive performance deficits, particularly among POWs surviving sustained malnutrition.

Continued DVA support was awarded in 1992 to conduct 5-year follow-up assessment of the original POW and combat veteran samples and to add 200 POW and combat-only veterans to the database. This research is extended to determine the limits of neurobehavioral deficiencies, assess replicability of findings over samples and time intervals within samples, evaluate the severity of demonstrated cognitive deficits, and define the spectrum of possible cognitive changes associated with POW trauma using tests of attention, explicit and implicit memory, immediate and remote memory, and executive/organizing functions against the backdrop of overall neuropsychological integrity. We will collect pilot magnetic resonance imaging data to explore whether former POWs, particularly those who sustained severe malnutrition in addition to prolonged life-threatening captivity, exhibit structural brain abnormalities consistent with identified deficits in memory, attention, and other neuropsychological functions.

A corollary to studies of neuropsychological functioning in former POWs is a preliminary investigation of learning and memory in Vietnam combat veterans with PTSD diagnoses. In comparison to controls, PTSD veterans showed significant deficits on measures of attention/concentration

and new learning of material presented in both visual and verbal formats. At present, our team is conducting research to replicate these findings and to describe cognitive functions, emphasizing learning and memory, among carefully matched groups of Vietnam veterans differentiated by PTSD diagnoses. Work examining possible mechanisms of attention and memory deficits in Vietnam veterans who suffer chronic PTSD, focusing specifically on learning patterns and sensitivity to interference in a verbal learning paradigm that incorporates trauma-relevant words, is also underway.

With establishment of an ODS Evaluation, Debriefing, and Treatment Team have come opportunities to study male and female troops who had been deployed to the Persian Gulf. We are conducting evaluation and debriefing sessions throughout Louisiana among National Guardsmen and Reservists. The small group debriefing protocol includes measures of personal demographics and resources, war-zone stress severity and characteristics, features of PTSD, negative affect states, and psychiatric symptoms. Results in the 213 respondents whose data have been analyzed to date point to frequent negative psychological outcomes and distress symptoms that may be attributed in large part to war-zone exposure. As many as 16-24% of troops exhibited symptomatology suggestive of clinical depression and PTSD. More thorough assessments conducted individually with members of a Quartermaster Company, troops hypothesized to be at high risk for psychological symptoms as a result of graves registration assignment, revealed high prevalence of PTSD and other disorders. There was little evidence of preexisting psychopathology, but 46% of troops who performed macabre body identification and recovery functions showed the full complement of PTSD symptoms and frequent depressive disorder comorbidities.

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